

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 1-30-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$650** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The therapeutic exercises, hot-cold pack therapy and aquatic therapy from 03-03-03 though 4-29-03 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 4-29-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Regarding CPT Code 97010 for dates of service 3-5-03 and 3-7-03: Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed service or services will be reviewed according to the Medicare fee guidelines. **Recommend reimbursement for CPT Code 97010 (2 x \$11.00) for a total of \$22.00.**

Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what

constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Additional reimbursement not recommended. **No reimbursement is ordered for CPT Code 97110 dates of service 3-5-03 and 3-7-03.**

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 3-5-03 and 3-7-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 1st day of October 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division
DA/da

NOTICE OF INDEPENDENT REVIEW DECISION

April 23, 2004

Re: IRO Case # M5-04-1557-01
IRO Certificate #4599

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the

proposed care to determine if the adverse determination was appropriate. For that purpose, ____ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Neurological Surgery, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ____ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ____ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient is a 44-year-old female who slipped on concrete and fell to her buttock in _____. She developed back pain, and physical therapy and medications were of no significant benefit. The back pain was soon associated with left lower extremity pain. Epidural steroid injections on three occasions were tried without help. On 11/8/02 a PLIF was performed at L5-S1. Post operatively the patient was improved, but she became somewhat worse when a physical therapy program was initiated. After the passage of several weeks, it was recommended that the patient resume physical therapy, which she did with a different therapist. The physical therapy pursued was beneficial. All of the measures, including therapeutic exercises, hot/cold packs and aquatic therapy were useful.

Requested Service(s)

Therapeutic exercises, hot/cold pack therapy, aquatic therapy 3/3/03 – 4/29/03

Decision

I disagree with the carrier's decision to deny the requested services.

Rationale

The physical therapy measures provided proved to be useful. It is not at all unusual for such physical therapy measures to be necessary after the performance of an operative procedure for a diagnosis of significant disk disease.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.